Additional Information Regarding Funding Request for Hospice Services

Ryan White Part A

June 2010

Individuals being admitted to Doug's House for hospice care are given a prognosis of 6 months or less to live by a physician and are thus eligible and appropriate for hospice care. Because the course of HIV/AIDS is so different among different people, it can never be foretold what the outcome will be, but we always want to offer people good care – focused on maximizing quality of life – and hope for the best. Since the population that we serve is rarely connected on a regular basis to primary care, some who are admitted with a hospice diagnosis experience an increase in health status – if only for a short time. Others, after accessing health care through our services, are able to maintain their health for extended periods. When this happens, the client is discharged into the care of an in-home hospice agency to be provided care.

When a client enters Doug's House, the first goal is to identify and address critical issues of pain and symptom management. This is done by establishing a cooperative relationship with a physician (typically at the David Powell Clinic), closely monitoring the client's medical condition and needs, and ensuring adequate nutrition consistent with the client's condition. As a result of these activities, and the supportive care provided, clients are maintained in treatment in a manner that takes advantage of every opportunity to experience improved health status. Virtually all clients experience an improvement in quality of life in terms of comfort, hygiene, safety and emotional well-being.

Some clients do experience improved health -- enough to leave the hospice (which does not mean that they go back to living totally independently or return to work). Clients leaving the hospice still carry a hospice diagnosis and are – in almost all cases – discharged with follow-up care from an in-home hospice provider such as Hospice Austin. Again, we cannot tell up front what the outcome of the medical and supportive care that hospice residents will be: will it be the ability to leave the hospice or will it be a more comfortable and dignified transition out of this life than they would otherwise experience? Our experience says that some will get better (likely for a time only) and others will not.

There is significant overlap between various health areas, and just because some hospice patients are able to become more ambulatory or more able to perform functions of daily living, as a result of the services provided in a residential hospice does NOT mean that the services being provided to those hospice patients should be classified as rehabilitation services. Any rehabilitation that occurs is an adjunct, an added bonus, to the primary purpose of the hospice services, which is to improve quality of life near and at the end of life.

In Central Texas there is no other option for this type of care. The only alternative would be hospitalization at a much greater cost to the community. Hospice clients experience a decrease in visits to the emergency room and subsequent inpatient hospitalizations are avoided thus reducing the total

costs to the community. Hospice Austin does operate a facility (Christopher House) for limited inpatient care (a few days) for pain and symptom management. This does not meet the needs of our clients.

Service capacity is limited by the size of the hospice facility – 5 beds. Intake appointments are made immediately upon referral for care and are made for the convenience of the client, whether it is in the hospital or at a client's place of residents. Intakes are almost always done within 24-hours of the referral. Most referrals come from area hospitals and in-home hospice agencies.

While intakes are accomplished in a timely manner, there is usually a waiting time for admission to care, depending on the availability of a bed. As services provided are critical-need services, the waiting list is not a first-come-first-served list. Rather, those with the greatest needs are served first no matter where they are on the list. While the waiting list for services can be typically 1-4 clients, we feel the available capacity adequately meets the demand for care. Were this service not being provided, there would exist a critical gap in the continuum of care for this community.

Current year Ryan White Part A funding is $70,000 for 247 units (Day of Care). We are asking for an additional 106 units to be funded from this allocation. As with the rental assistance request submitted, this figure represents a shortfall for this grant year. While we are hopeful that RWA funding will be restored to the 09/10 level for the next grant year, we will continue to aggressively pursue other funding sources.